Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Medical Assistance Administration

Direct Entry

Training Manual

May 2000

About this publication

This publication supersedes all previous MAA Direct Entry Billing Manuals.

Published by the Medical Assistance Administration
Washington State Department of Social and Health Services
May 2000

Received too many billing instructions?
Too few?
Address incorrect?

Please detach, fill out, and return the card located inside the back cover of this billing instruction. The information you provide will be used to update our records and provider information.

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Important Contacts

A provider may use MAA's toll-free lines for questions regarding MAA's programs; however, MAA's response is based solely on the information provided to the representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern MAA's programs.

Where do I call for information on becoming a DSHS provider?

Provider Relations Unit
(800) 562-6188
-or-
Provider Enrollment Unit
(360) 725-1026, (360) 725-1032,
(360) 725-1033

Whom do I call for authorizations?

Acute Physical Medicine & Rehabilitation	**(800) 634-1398**
Durable Medical Equipment & Prosthetics & Orthotics	**(800) 292-8064**
Hospice	**(800) 545-5392**

Note: Hospice requires provider notification within 5 days of client admit. Providers must fax the 5-day notification (see Hospice Billing Instructions) to: (360) 586-5299
or call (800) 545-5392

Where do I get copies of billing instructions?

Check out our web site
http://maa.dshs.wa.gov **or-**
Provider Relations Unit
PO Box 45562
Olympia, WA 98504-5562
(800) 562-6188

Whom do I contact if I have questions on…

Billing procedures, payments, denials, or Explanation of Benefits (EOB) on Remittance and Status (RA) Report?

Provider Relations Unit
(800) 562-6188

Home Health Program Medical Review?
(360) 725-1582

Private insurance or third party liability, other than Healthy Options?

Division of Client Support
Coordination of Benefits Section
PO Box 45565
Olympia, WA 98504-5565
(800) 562-6136

Direct Entry Batch Number?
(360) 725-1950

Where do I send back-up information?

Division of Program Support
Claims Control Unit
PO Box 45560
Olympia, WA 98504-5560

Home Health Backup:
Quality Fee-for-Service
Home Health Nursing Care Advisor
PO Box 45506
Olympia, WA 98504-5506

Other Important Numbers

Client Assistance/ Brokered Transportation Hotline **(Clients Only)**	1-800-562-3022
Disability Insurance	1-800-562-6074
Durable Medical Equipment (DME)/Prosthetics & Orthotics Authorization **(Providers Only)**	1-800-292-8064
Fraud Hotline	1-800-562-6906
Healthy Options Enrollment	1-800-562-3022
Provider Inquiry Hotline **(Providers Only)**	1-800-562-6188
Telecommunications Device For The Deaf (TDD)	1-800-848-5429
Third-Party Resource Hotline	1-800-562-6136

Program Support Field Representatives

(360) 725-1022
(360) 725-1023
(360) 725-1024
(360) 725-1027
(360) 725-1020

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Definitions

This section defines terms and acronyms used in these billing instructions.

Authorization - Official approval for department action.

Authorization Number - A nine-digit number, assigned by MAA that identifies individual requests for services or equipment. The same authorization number is used throughout the history of the request, whether it is approved, pended, or denied.

Authorization Requirement - In order to obtain authorization for some services and equipment, you must provide proof of medical necessity. Each request must include a complete, detailed description of the diagnosis and/or any client-specific disabling conditions, justifying the need for the equipment or the level of service being requested.

Batch – A group of claims (all of the same claim type) that a provider and or intermediary submits to MAA via the Direct Entry System. Each group of claims (up to 100 claims) are assigned a Julian Date and a unique number known as a batch number.

Carrier - A private organization (usually an insurance company) that has a contract with the federal government to 1) review, approve and/or deny claims, and 2) process the paperwork for Medicare Part B (medical insurance). For Medicare Part A, these companies are called *intermediaries*.

Claims – Medical bills or invoices for services provided to Medical Assistance clients.

Client - An applicant for, or recipient of, DSHS medical care programs.

Code of Federal Regulations (CFR) - A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Community Services Office (CSO) - An office of the department that administers social and health services at the community level. (WAC 388-500-0005)

Core Provider Agreement - A basic contract that the Medical Assistance Administration (MAA) holds with providers serving MAA clients. The provider agreement outlines and defines terms of participation in the Medicaid program.

Deductible - An initial specified amount that is the responsibility of the client.

(a) `Part A of Medicare - inpatient hospital deductible' means an initial amount of the medical care cost in each benefit period which Medicare does not pay.
(b) `Part B of Medicare - physician deductible' means an initial amount of Medicare Part B covered expenses in each calendar year which Medicare does not pay.
(WAC 388-500-0005)

Department - The state Department of Social and Health Services.
(WAC 388-500-0005)

Direct Entry – An on-line system that enables a provider to enter Medical Assistance claims via the same on-line system used by MAA. The claim is then edited interactively for data validity, eligibility and TPL. The system also provides inquiry access to client eligibility and TPL Healthy Options information

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives information about the claim.

Explanation of Medicare Benefits (EOMB) – A federal report generated for Medicare providers that display transaction information regarding Medicare claims processing and payments.

Expedited Prior Authorization (EPA) - The process of authorizing selected services in which providers use a set of numeric codes to indicate to MAA which acceptable indications, conditions, diagnoses, and/or criteria are applicable to a particular request for services.

Intermediary – A third party employed by the Medical Assistance provider to submit claims to the Division of Program Support.

Julian Date – Consecutively numbered day of the year (e.g., January 1 is 001, January 31 is 031, February 1 is 032, etc.).

Managed Care - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services.
(WAC 388-538-050)

Maximum Allowable - The maximum dollar amount that a provider may be reimbursed by MAA for specific services, supplies, or equipment.

Medicaid - The state and federal funded aid program that covers the Categorically Needy Program (CNP) and Medically Needy Program (MNP).

Medicaid Management Information System (MMIS) – The systems, structures, and program that MAA uses to process medical claims.

Medical Assistance Administration (MAA) - The administration within the Department of Social and Health Services authorized by the secretary to administer the acute care portion of the Title XIX Medicaid and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medical Assistance IDentification (MAID) card – MAID cards are the forms DSHS uses to identify clients of medical programs. MAID cards are good only for the dates printed on them. Clients will receive a MAID card in the mail each month they are eligible.

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology/ [audiology] services, home health care, and other health services and supplies not covered under Part A of Medicare. (WAC 388-500-0005)

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each Medical Assistance client consisting of the client's:

- First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Personal Computer (PC) – A desktop, floor standing, or portable microcomputer that usually consists of a system unit, a display monitor, a keyboard, one or more diskette drives and or internal fixed drive.

Prior Authorization – The approval provider's must obtain from MAA for certain medically necessary services, items, or supplies.

Program Support, Division of (DPS) - The division within the Medical Assistance Administration responsible for providing administrative services for the following: Claims Processing, Family Services, Managed Care Contract Management, Provider Relations, Field Services, and Regulatory Improvement.

Provider or Provider of Service - An institution, agency, or person:

- Who has a signed agreement [Core Provider Agreement] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. (WAC 388-500-0005)

Remittance And Status Report (RA) - A report produced by the MMIS system that provides detailed information concerning paid, returned, pending, denied and adjusted claims. This report is produced once each week for each provider who has MAA claims activity.

Revised Code of Washington (RCW) - Washington State laws.

Submitter – A provider or intermediary submitting claims to Division of Program Support/Office of Information Services.

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical program client. (WAC 388-500-0005)

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.
(WAC 388-500-0005)

Washington Administrative Code (WAC) Codified rules of the State of Washington.

Getting Started

What forms must I fill out prior to submitting Direct Entry claims?

Before submitting Direct Entry claims to the Medical Assistance Administration (MAA), each provider and/or intermediary must fill out the following Electronic Media Claim (EMC) agreements and send them to MAA at the address listed on the next page.

- **Electronic Billing Agreement** – Completed by all providers and/or their intermediaries who wish to submit electronic claims information. This document details the responsibilities of the MAA provider.

- **Request For Submitter Identification Number** - Completed by the submitting entity.

- **Disclosure Statement** – Completed by providers and/or intermediaries who use the Direct Entry billing option.

- **Power of Attorney** – Completed by providers who use an outside firm (i.e., an intermediary) to submit their direct entry information.

  The Power of Attorney document transfers the signatory rights to the data processing firm to certify that the submitted data meet the requirements of the Federal Fraud and Abuse Act. The Power of Attorney must be notarized.

  Blank agreements are available from the Division of Program Support (DPS) by calling 1-800-562-6188 and selecting Option 1.

Important information for you to know!

According to **42 CFR 447.10(f)**, payment made to the intermediary by the provider must be based upon the cost of processing the provider's claims, and may not be related to a percentage or other basis of the amount billed or collected. Payment to the intermediary may not be dependent upon payment by the State for the provider's claims.

Disclosure of applicant and client information

Federal and state regulations limit the disclosure of applicant and client information. As a Medical Assistance provider using the direct entry system to bill MAA, you have access to client eligibility, Healthy Options, and third party resource information, as well as claims entry screens. The Disclosure of Information letter attached to your billing agreement must also be signed by an authorized representative. It is the provider's responsibility to ensure compliance with the referenced federal and state regulations.

If you give access or disclose information to any unauthorized person(s), you are in violation of this disclosure policy and have committed a gross misdemeanor. [Refer to RCW 74.04.060]

Where do I send the completed EMC forms?

Division of Program Support
Provider Enrollment Unit
PO Box 45562
Olympia, WA 98504-5562

What are the Direct Entry system's hours of operation?

The Direct Entry system is available for entering claims:
Monday through Friday
6:00 AM to 5:15 PM
5:30 PM to 11:00 PM
(excluding state holidays and unexpected computer downtime)

How do I activate a batch?

Call (360) 725-1950 to activate a batch.

MAA assigns batch numbers between the hours of:

7:30 A.M. to 11:30 A.M. - Monday through Friday
12:00 P.M. to 4:00 P.M. - Monday through Friday

What does a batch number look like?

(claim medium)-(year)-(Julian date)-(microfilm #)-(batch #)

1 - 00 - 300 - 51 - 700

EXAMPLE: Batch number **1-00300-51-700**:

1	Identifies the claim medium (In this case, direct entry)
00	Year the batch was requested
300	Julian Date (or consecutive day of the year)
51	Microfilm Machine Number
700	Batch # for Julian Date on Direct Entry

Note:

The Internal Control Number (ICN) that appears on your RA is comprised of the batch number, six character claim number.

Claims Entry

1. Turn your terminal (CRT) on.

2. Enter your commands to access the system.

3. Key: **MMIS** (Medicaid Management Information System) and press **ENTER**.

4. The MMIS *Applications Menu* will appear as shown:

CLAIMS EXAM ENTRY

WASHINGTON MMIS ON-LINE APPLICATIONS

01. CLAIMS EXAM ENTRY 09. RECIPIENT MASTER FILE

PLEASE ENTER THE CODE NUMBER OF THE DESIRED APPLICATION, YOUR IDENTIFICATION NUMBER, AND SECURITY CODE. DEPRESS THE ENTER KEY.

CODE NUMBER: IDENTIFICATION NUMBER SECURITY CODE:

__ __ ___ ___ ___ ___ ___ ___

The security code is a masked field and will not appear when keyed.

5. To select an application, key in the screen *code number* (01, in this case), your *identification number, and security code*. Press **ENTER.**

Security codes expire every 6 months (whether used or not).
Follow the screen prompts to activate new security codes.

6. The *Batch Information* screen will appear as shown below:

CLAIMS EXAM ENTRY

BATCH DATE __ __ __ __ __ BATCH NUMBER __ __ __

TOTAL DOCUMENTS __ __ __ MICROFILM MACHINE/NUMBER __ __

TYPE OF CLAIM __ PROVIDER NUMBER __ __ __ __ __ __ __

*D - DRUG	M - OUTPATIENT HOSPITAL	*T - NURSING HOME
*I - CLAIM ADJUSTMENT	*O - MEDICARE PART-B	*U - CONGREGATE CARE
J - PRACTITIONER	P - VENDOR	*V - MEDICARE INPAT X-OVER
K - DENTAL X-OVER	*Q - GROSS ADJUSTMENT	*W - MEDICARE OUTPAT
L - EPSDT	R - DRG HOSPITAL	*Z - CLAIM CREDIT
	S - INPATIENT HOSPITAL	

ACCOUNTING-CODE: __ (0-PAY PROVIDER 1-HISTORY ONLY)

*** Screens not available to direct entry users**

7. To begin a batch, you must complete all of the following fields:

- Batch date;
- Batch number;
- Total documents;
- Microfilm/machine number;
- Type of claim;
- Provider number; and
- Accounting code **(Always use accounting code "0".)**

Valid microfilm machine numbers are:

11 - Practitioner/EPSDT
21 - Medical Vendor
51 - Hospital (Outpatient, DRG, Inpatient)
61 - Dental

8. Complete the *Batch Information* screen and press **ENTER**.
   The *Claims Entry* screen will appear.

9. Enter all required data, and press **ENTER**.
   If exception codes do not appear, a new claims screen will appear.

10. If exception codes appear, correct the applicable exceptions. After correcting the exceptions, press **ENTER**. (See *Other Important Information*, page 14).

11. If exception codes still appear on the claim and you cannot make further corrections, press **PA2** to force the claim into the system and bring up the next sequential claim number.

12. After each claim is accepted/forced (by using the PA2 key), the system will automatically sequence to the next document number. You **must** manually change check digits (the two digits that appear after your ICN number) so that they correspond with the claim number.

13. Claims are entered in batches of **100 or fewer**.

14. After you have completed keying claims for a batch, press **PA1** to verify the number of claims keyed. If claims are not all accounted for, press **PF1** and verify keyed claim numbers. Reaccess the *Batch Information* screen by pressing **ENTER** twice, and enter any claim numbers which may have been omitted.

15. If all claims are accounted for press **PA1** to close the batch and exit the system.

16. If fewer claims have been keyed than were requested and activated, and no additional documents need to be entered, contact the Claims Control Unit at (360) 725-1950. Provide the correct claim count so the batch can be closed.

Claims will not be processed until the batch is closed.
DPS will automatically close all batches that have been open for seven business days.

Recipient Master File (Eligibility)

Accessing the Recipient Master File

1. To access the Recipient Master File from the *Applications Menu* (see page 8), key in the *screen code number* (in this case, 09), your *user identification number and security code.* Press **ENTER**.

2. The *Recipient Inquiry* screen will appear.

3. Press **I** (Inquire) and enter the complete Patient Identification Code (PIC). Press **ENTER.**

> You may also obtain access to the Recipient Master File (Step 3) by entering any of the following:
>
> - Client's social security number;
> - HIC number; or
> - Client's case number (identifies all clients in the family).
>
> Enter the line number corresponding to the desired family member.

4. The first page of the Recipient Eligibility File will appear.

5. Pressing the **PF2** key will give you covered eligibility for your client.

6. Pressing the **PF1** through **PF6** keys will page you back and forth through the file.

7. To exit the Recipient Eligibility File, press **PA1**.

Accessing Third Party Liability (TPL) Information

1. To access TPL information in the Recipient Eligibility File, press the **PF4** key. Press the **PF5** key to access all additional TPL payors.

2. To exit the Recipient Eligibility File, press the **PA1** key.

Accessing the Healthy Options Program

1. The Healthy Options Program can be accessed by pressing the **PF6** key. This allows you to determine the client's managed care plan or primary care case manager (PCCM).

   The following indicators will be in the *Healthy Options* column:

C	-	Enrolled in a Capitated Managed Healthcare Plan
F	-	Fair Hearing in Process
M	-	Refund for Dual Coverage
O	-	Other
P	-	Enrolled in Primary Care Case Management (PCCM)
R	-	Recoup for Dual Coverage
S	-	State Paid Premium Payment
X	-	Premium Recoupment (being recouped)
Z	-	1-Day Segment (Not Covered by MHC)
1	-	Medical Reasons (Includes Plan/Provider Request)
2	-	Pregnant
3	-	Travel
4	-	TPL
5	-	Homeless
6	-	Indian
7	-	Pending Decision (State)

2. To exit the Recipient Eligibility File, press **PA1**.

For a Key to the Eligibility Codes in the Recipient Master File, See Appendix A.

Direct Entry/Suspense Corrections

The Direct Entry and Suspense Correction functions use selected keys on the keyboard. The following section describes how these keys are used. Your keyboard may have a conversion key sequence to accomplish the same functions.

ENTER: This is the edit key. When the claim information is keyed on the screen, pressing this key indicates that you now want the system to edit the claim.

PA1: This key is used to return to the previous screen. It is also used to return to the Batch Information screen when all the claims for a batch have been entered.

PA2: This key forces the MMIS system to accept the claim and to present a new claim screen when unresolved exception codes remain that will not be addressed.

PF1: This key scrolls the screen so that additional claim detail information can be entered.

PF2: This key accesses exception code descriptions. If more than five exception codes are on a claim, a highlighted "+" sign will appear at the end of the last, visible exception code. Press this key to display the next group of five exception codes. A description of the first exception code will appear at the bottom of the screen. To view another exception code description, place the cursor in the *ST* (status) column of the desired code and press this key.

PF4: This key accesses the Recipient Eligibility File. Place cursor under Patient Identification Code (PIC) and press **PF4**. Press a second time to access clients insurance file.

PF5: In the Recipient Eligibility File, this key accesses additional insurance information for the claim shown on the screen.

PF6: In the Recipient Eligibility File, this key accesses information pertaining to a client's enrollment in a managed care plan or with a primary care case manager. On the UB-92 hospital claim form, this key also accesses page 2. Press key again to return to page 1.

ERASE-EOF:

Placing the cursor at the beginning of any field and pressing this key will delete the information in that particular field. However, this key will only delete a field before you press the **Enter** key. Once you have "edited" the data with the **Enter** key, it can only be deleted by pressing the *space bar* in an alpha field or by zeroing out numeric fields with the *0* key, character by character. You may key over existing data at any time.

CLEAR: This key will clear any information entered on the claim screen, so you can re-enter the claim or begin a new one.

Other Important Information

1. The **Enter** key must be pressed to "lock-in" any data.

2. If a problem occurs when entering data on the screen, and you are unable to resolve it, press the **PA1** function to clear the screen and restart the entry process.

3. Exception codes with a 1, 2, or 3 in the *ST* column should be addressed before transmitting the claim. Check exception codes with a short description preceded by *(NA)* for keying errors and for documentation or approval requirements. If necessary, refer to MAA's specific program billing instructions or fee schedules for assistance. Exception codes with a 4 or 5 in the *ST* column do not need to be addressed; they are informational only.

4. It may be necessary to resolve an exception code by denying it. This is accomplished by placing the cursor under the *ST* column and key a "**D**". For example, you may want to deny a code when a timely claim number from a remittance report is not readily available. The claim could then be rebilled at a later time when proper documents are acquired.

   Only those exception codes that are not preceded by *(NA)* AND have a 3 in the *ST* column can be denied at the direct entry level. If an exception code has been denied in error, key a "**C**" over the "**D**" in the *ST* column, and press **ENTER**. This will restore the code's original disposition status.

   NOTE: DPS may change the status of any exception without notice.

5. All claim types will accept multiple line items per page.

Claim Type	Maximum Line Items
Physician (J), Medical, Vendor (P), EPSDT (L)	21
Dental (K)	24
Outpatient (M)	40
Inpatient (S)	40
DRG (R)	40

   To access a new page for entry of additional line items, press the **PF1** key. Continue numbering the lines in sequential order. To delete a line, key two periods (..) over the line number and press **ENTER**.

6. **You must always be at the beginning of a field when entering data.**
Failure to do so may transmit incorrect information or block your transmission. **Use the *Tab* key when moving to fields to ensure you are at the beginning of that field.** Do not use the *Space Bar* or *Arrow* keys to move into fields.

7. When applicable, use indicator **B** in the *ITA* field to indicate *Baby on parent's PIC (60-day limitation and only if baby has not been assigned their own identification PIC).* A statement in remarks is only required if indicating Twin A or B.

8. The *ITA* (Involuntary Treatment Act) field can be used for indicating voluntary and involuntary treatment. **I** = involuntary; **V** = voluntary.

9. On UB-92 billings, enter the referring PCCM (Primary Care Case Manager) in the *O-Prov* (other provider) field, if applicable.

10. When billing for newborns using the mother's PIC on the UB-92 claim form, enter **J0 (zero)** in the *Occurrence Code* field and the baby's birthdate in the corresponding *Occurrence Date* field.

Remarks Entry Screen

The *Remarks Entry* screen is accessed by inserting a **Y** in the *REM* field. The number of available comment lines is determined by the number of detail line items billed on the claim. Up to 40 characters may be entered per line.

Any data entered in the *Remarks Entry* screen will suspend your claim. A claims examiner will then adjudicate the claim based on the contents of the *Remarks* and/or backup documentation. (See page 18 for further Backup information.)

To expedite claims processing, providers and intermediaries are requested to use the *Remarks Entry* screen instead of backup documentation. After using the *Remarks Entry* screen in lieu of backup documentation (for example, approved extension requests), you should keep the source documents for a period of six years from the date of service.

Make sure the remarks entered are essential to the processing of the claim. All claims with remarks will be reviewed. **Messages such as procedure code descriptions or diagnosis descriptions are unnecessary and will cause needless delay in claims payment.** Appropriate messages may include, but are not limited to, the following:

"Ventilator patient"
"Rebilling - ICN 10000911005000100"******
"Fell at home - no insurance involvement"
"Twin A" or "Twin B"
"PAS Extension"
“Not covered under client’s Healthy Options plan”

**** If timeliness is a factor (exception code 125), indicate the original claim number (ICN) to verify that the claim was submitted within the 365-day billing limitation period.**

Insurance Remarks

If there is a possibility of other insurance involvement, the *Remarks Entry* screen may be used in place of the Injury Report Form.

Providing the following information will help MAA expedite the processing of your claim. If you have keyed an **Y** in the *TPL* (Third Party Liability) field on the screen, you must supply information in the *Remarks Entry* screen or submit backup documentation concerning the insurance. (If you have additional questions concerning what information is necessary, call **TPL at 1-800-562-6136.**)

Information to Provide for Casualty Cases (as applicable)

1. How, where and when injury occurred; for example, fell at home - 6/1/00, MVA (motor vehicle accident) - 6/1/00; and

2. Name(s) and telephone number(s) of the insured, insured's attorney, insurance company, and those involved in the accident.

Information to Provide for Health Insurance Cases (as applicable)

1. The name, telephone number, and address of the insured's insurance company, (Blue Cross, Champus, Travelers, etc.);

2. The name and telephone number of insured/subscriber and his/her employer;

3. The insured's Social Security Number;

4. The insured's employer's name and telephone number; and

5. The insured's policy or group number.

Claims Requiring Remarks/Comments or Backup Documentation

Most claims can be billed electronically regardless of whether it needs backup documentation or special comments to explain unusual circumstances.

When are comments or documentation required?

MAA suggests that providers familiarize themselves with MAA program specific billing instructions and numbered memoranda to know when billings will require *Remarks/Comments* or backup documentation.

Many times, providers submit documentation or *Remarks/Comments* when there is no requirement to do so. This will slow processing! If you are in doubt about whether to send backup documentation or enter *Remarks/Comments*, please call the Division of Program Support toll-free at 1-800-562-6188.

Examples of electronic claims that may require backup documentation or Remarks/Comments are:

- Third Party Liability (Insurance) claims-injury reports, Explanation of Benefits (EOB) from insurance companies, Medicare, etc.
- Claims where Medicaid eligibility is newly established or in question.
- Claims for procedures that are listed in MAA's fee schedule as "By Report" under the Maximum Allowable column.
- Claims which require special handling.
- Claims for home health providers during an agency designated review period. Home Health documentation must be mailed prior to submitting electronic claim if the client is on Focused Medical Review. Mail justification to: Home Health Nursing Care Advisor, PO Box 45506, Olympia, WA 98504-5506.
- Claims for both miscellaneous oxygen-related durable medical equipment and repairs and non-routine service on medical oxygen equipment.

Backup Documentation

If the *Remarks/Comments* field does not allow you enough space to provide information to process your claim, you may need to send hard copy documentation to support the billing. Information that cannot be transmitted electronically, but necessary to correctly process an electronic claim, is considered backup documentation.

Examples of backup documentation are: Copies of the Medical Assistance IDentification (MAID) cards, Remittance and Status Reports, consent forms, insurance denials, operative reports, home health plan of treatment, and dental charts.

- If documentation must be submitted separately, place an indicator in the first position of the *Remarks/Comments* field. This indicator will cause the claim to suspend and will indicate to the claims examiner that documentation has been submitted separately.

- The following indicators have been assigned for this purpose:

"X" Every claim submitted with **non-insurance related** backup documentation must have an "X" in the first position of the *Remarks/Comments* field.

Claims for clients under the Involuntary Treatment Act (ITA) must have the appropriate program forms submitted as backup documentation (e.g., DSHS 13-628: Client Information Involuntary Treatment Act, DSHS 14-01: Request for Assistance). Enter an "X" in the ***Remarks/ Comments*** field to indicate backup is being sent. Also enter the letters "ITA" in the ***Remarks/Comments*** field.

"I" Every claim submitted with **insurance related** backup documentation must have an "I" in the first position of the *Remarks/Comments* field.

If you have both types of backup, use both the "X" and the "I" in the first and second position of this field.

For casualty/accident claims, send applicable accident or injury report. Include how injury occurred, name, address, and telephone number of attorney, insurance company, and insured, and where the injury occurred.

For health insurance claims, send insurance company EOBs showing unmet deductibles, noncovered charges, noncovered dates, coverage termination dates, noncovered patients, and insurance payments showing that insurance paid less than the DSHS maximum allowable amount.

The "X" and "I" identifiers are the ONLY way to alert the claims processing staff to match the claim with the backup documentation.

Submit backup in the following manner:

Immediately after you have finished your batch, follow the procedures below to submit backup documentation:

- Documents smaller than the standard 8-1/2" x 11" size (e.g., MAID cards, invoices, Remittance Advices) must be taped or copied onto 8-1/2" x 11" sheets of paper so the documents are not lost and can be easily microfilmed.

- The backup Detail Form must be attached to a Batch Header sheet and a Client Listing. (See pages 22-25 for a sample copy.) You must submit only **one** Batch Header and **one** Client Listing **per batch**.

  - ✓ Organize all backup documentation in order **BY CLAIM NUMBER.**
  - ✓ Place a Backup Detail Sheet in front of each client's documentation.
  - ✓ List each client's name on the Client Listing form in order **BY CLAIM NUMBER** (see sample form, page 23-24).

- Attach the Batch Header Sheet to the Client Listing and Detail Form, along with the backup documentation. Mail it to the DPS address listed on the Batch Header Sheet. (See attached samples.) To order additional backup documentation forms, call one of the following DPS field service telephone numbers:

(360) 725-1022
(360) 725-1023
(360) 725-1024
(360) 725-1027
(360) 725-1020
OR
(800) 562-6188

- ✓ DPS will hold suspended claims awaiting receipt of backup documentation for 10 working days after the batch is closed.

- ✓ If required backup documentation is not received within that time, DPS will deny the claim(s) in question and notify the provider via the Remittance and Status Report (RA) with a message stating "Backup documentation required for processing was not received."

All claims that suspend for backup documentation or comments will require manual processing which takes additional time.

NOTE: Home health backup documentation is not microfilmed. It must be mailed directly to:

Quality Fee-for-Service
Home Health Nursing Care Advisor
PO Box 45506
Olympia, WA 98504-5506

Completing the Batch Header

① List the **provider name or facility name** document(s) are coming from.

② Enter one of the **claim types** below:

PHYSICIAN	**J**	**DENTAL**	**K**
EPSDT	**L**	**INPATIENT**	**S**
MEDICAL VENDOR	**P**	**DRG**	**R**
		OUTPATIENT	**M**

③ Enter the **billing provider number.**

④ Number of documents attached.

⑤ Year, Julian date, and batch number that MAA issued for this batch.

Remember to submit a separate Batch Header sheet for each different batch. Each batch is issued a separate claim number series, therefore it must be submitted with its own Batch Header sheet to ensure proper matching of the direct entry claim to the backup documentation.

Backup documentation must be received by the Division of Program Support (DPS) within 10 working days after the batch is closed.

Send your backup to:
DIVISION OF PROGRAM SUPPORT
ATTN: CLAIMS CONTROL UNIT
PO BOX 45560
OLYMPIA WA 98504-5560

DIRECT ENTRY
BATCH HEADER
BACKUP DOCUMENTATION

(FILL OUT COMPLETELY – CHECK YOUR ACCURACY!)

Provider Name _____ Claim Type _____

Provider Number _____ Number of Documents Attached ____

Medium Indicator	Year	Claim Date						Batch Number		
1						* * *				

MAA must receive your backup documentation within ten (10) working days after the batch is closed.

Send to: Division of Program Support
Post Office Box 45560
MS: 45560
Olympia, WA 98504-5560

IMPORTANT!

YOU MUST COMPLETELY FILL OUT THIS FORM, ALONG WITH A CLIENT LISTING AND DETAIL FORM, FOR EACH BATCH. OTHERWISE, MAA WILL RETURN THE BATCH TO YOU.

DIRECT ENTRY CLIENT LISTING

(Sort and List Documents in Order by Claim Number)
BATCH HEADER BACKUP DOCUMENTATION

Document No.	LAST NAME FIRST MI	Document No.	LAST NAME FIRST MI
00		26	
01		27	
02		28	
03		29	
04		30	
05		31	
06			
07		33	
08		34	
09		35	
10		36	
11		37	
12		38	
13		39	
14		40	
15		41	
16		42	
17		43	
18		44	
19		45	
20		46	
21		47	
22		48	
23		49	
24		50	
25		51	

<u>NOTE</u>: Make sure you put the client's name next to the appropriate claim number; <u>not</u> in alphabetical order, otherwise MAA will return the batch to you.

Document No.	LAST NAME FIRST MI	Document No.	LAST NAME FIRST MI
52		76	
53		77	
54		78	
55		79	
56		80	
57		81	
58		82	
59		83	
60		84	
61		85	
62		86	
63		87	
64		88	
65		89	
66		90	
67		91	
68		92	
69		93	
70		94	
71		95	
72		96	
73		97	
74		98	
75		99	

NOTE: Make sure you put the client's name next to the appropriate claim number; not in alphabetical order, otherwise MAA will return the batch to you.

IMPORTANT!

YOU MUST COMPLETELY FILL OUT THIS FORM, ALONG WITH A BATCH HEADER AND DETAIL FORM, FOR EACH BATCH. OTHERWISE, MAA WILL RETURN THE BATCH TO YOU.

BACKUP DETAIL FORM

DIRECT ENTRY

Claim Number: _____

(FILL OUT COMPLETELY – CHECK YOUR ACCURACY)

Number of Documents Attached: _____

IMPORTANT!

YOU MUST COMPLETELY FILL OUT THIS FORM, FOR <u>EACH</u> CLIENT'S BACKUP DOCUMENTATION YOU SUBMIT. OTHERWISE, MAA WILL RETURN THE BATCH TO YOU.

Rebillings and Adjustments

Rebillings and adjustments are important steps in correcting any billing problems. Knowing when to use the rebilling process rather than the adjustment process is important and will save you time and frustration. **State law requires providers to submit their claims to MAA within 365 days from the date of service (RCW 74.09).**

- Providers may **resubmit or adjust** any timely initial claim, except pharmacy claims, for a period of 36 months from the date of service.

  Note: MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The allotted time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time period, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

Rebillings

Providers should **rebill** when:

- **The claim is denied in full due to an error in billing**. When the entire claim is denied, make the appropriate corrections and resubmit the claim.

- **An individual line is denied on a multiple-line claim due to an error in billing**. The denied service by itself may be submitted as a rebill, unless the claim contains multiple surgical procedure codes. (See Adjustments on next page.)

- **The claim does not appear anywhere on the Remittance and Status Report.** If 90 or more days have elapsed since you sent your claim to MAA and it has not appeared on the Remittance and Status Report, resubmit the claim to MAA.

Remember...to be considered for payment, your claim must be received by MAA within 365 days from the date you provided the service.

When submitting a rebilling that is beyond the 365-day billing time limit, reference the Internal Control Number (ICN) in the Remarks/Comments field that reflects the specific denial. This will verify that your claim was originally submitted *within* the appropriate time limit.

Adjustments

Adjustments **cannot** be billed through the Direct Entry process.

How to submit adjustments

- All **adjustments** must be submitted on the **blue Adjustment Request** form (DSHS 525-109).
- Use only one adjustment request form per claim (ICN).
- Submit multiple line corrections to a single claim on **one** adjustment request form.

Rebillings are not appropriate for the following situations. You must submit an adjustment when:

- **The claim was paid.** Claims or line items paid at an amount less than MAA's maximum allowable amount must be rebilled as an adjustment. If your charges are less than the maximum allowable amount, MAA will pay your claim as billed.
- **The claim was paid, but an error occurred** in procedure codes, diagnoses coding, or anything else that may affect payment.
- **The claim contained multiple surgical procedure codes, and one of the surgical procedures was denied or paid incorrectly.**
- **The claim was overpaid.** If you discover an overpayment, submit an adjustment. MAA will adjust your claim accordingly.

Helpful Hints

Typing Errors

Check for transposition of numbers, especially in authorization numbers. Remember to verify numbers before transmitting.

Remarks

Unnecessary and/or inappropriate remarks delay claim processing. Do not put an **X** or **Y** in the *Remarks/Comments* field until you are sure the remarks are needed.

Submitting Improper Forms

Always use the Batch Header Cover Sheet, Client Listing and Backup Detail Forms to help identify backup information. Use one Batch Header Form per batch, not per claim. **All fields on the forms MUST be filled in. Forms will be returned if all required fields or forms are not completed.**

Always Verify Claim Information
Before Transmitting The Claim To MAA.

MAKE SURE YOU PUT THE CLIENT'S NAME NEXT TO THE APPROPRIATE CLAIM NUMBER; NOT IN ALPHABETICAL ORDER.
MAA WILL RETURN THE BATCH TO YOU IF FILLED OUT INCORRECTLY.